MEDICAL SOCIETY
State of California

IMPORTANT NOTICE!

San Francisco, October 15, 1914.

Dear Doctor:

Vote "NO" on Initiative No. 46, on the ballot for the election November 3d, and get all the voters you can to do likewise. It would be a great injury to have this become a law. It would license every quack in the State, allow them to perform all kinds of surgery, sign death certificates, call themselves "Dr.," etc.

Get in touch with the secretary of your county society and find out the details.

Cordially yours,

PHILIP MILLS JONES, *Secretary.*

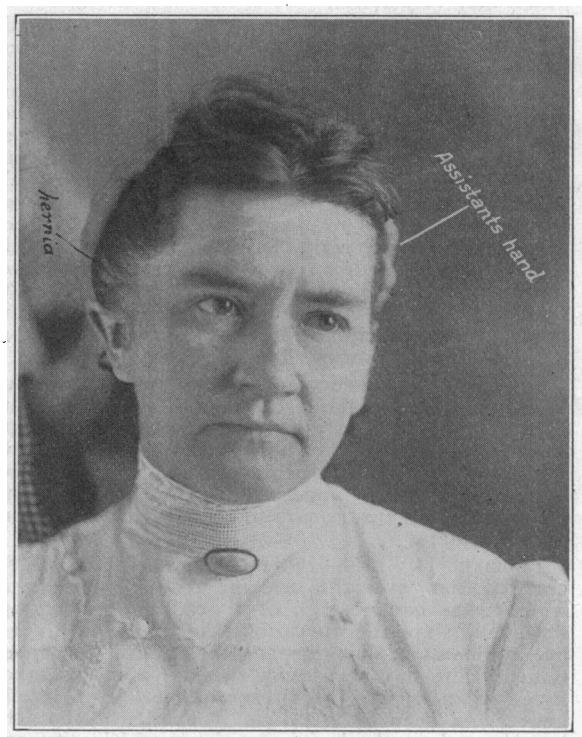
"DECOMPRESSION IN ACQUIRED INTERNAL HYDROCEPHALUS."

Report of Case.

By CECIL E. REYNOLDS, M. R. C. S. Eng., L. R. C. P. Lond., D. P. H., Cambs, Los Angeles.

Mrs. H. L. S., aet. 34, had suffered from headache since childhood, but can fix no definite onset. The headache was general in character, worse at the occiput and accompanied by "cramping spells" in which the arms and legs were drawn up, and the head retracted. Consciousness was sometimes lost in these fits, but not always, and the bladder and rectum never acted involuntarily. Vertical diplopia was, however, complained of, and when walking in the street passers-by appeared to have two heads—one on top of the other at times. Formerly she would remain free from attacks for years at a time, but of late the attacks occurred every two or three months. Occasionally she vomited. She has worn reading glasses for two years, but they were prescribed by an optician. No oculist had ever examined her eyes.

Four months prior to the time I first saw her, on July 12, 1913, the headache and vomiting became more intense and the "cramping spells" became more frequent, and appear to have had Jacksonian qualities. The right arm was more affected than the left, and the face was quite unaffected. She steadily lost weight. Upon turning the head quickly, especially to the left, she experienced great vertigo, and her description of this much resembled Meniere's syndrome, and she staggered in walking (she thinks to the left). On July 12, 1913, Dr. Alfred Fellowes, who had charge of the case, called me in consultation. I found the patient in great distress—she vomited when attempting to sit up in bed, and complained of intense headache, general in character. She could not clearly see people in the room; her pulse was 80, temperature normal. She complained of numbness in the ring and little fingers of the right hand, but sensation was unaltered there and elsewhere. The patient is right-handed. There were absolutely no focal signs; no ptosis, nystagmus or strabismus. Both knee-jerks plus and equal—no ankle clonus. Plantar reflex flexor both sides. Power sensation and co-ordination normal and equal. No ear, nose, scalp or lung disease. Blood pressure not taken, but it was raised to the finger. Lumbar puncture not performed owing to dangerous intra-cranial pressure. Dr. Swift confirmed the optic neuritis, but the patient's relatives were averse to operation, and accordingly she was put on large doses of pot. iod. in spite of the fact that the blood yielded a negative Wassermann, by Dr. Bonynge. As, however, no improvement took place, the patient asked for further consultation, and Drs. H. G. Brainerd and McCleish confirmed the urgency of operation; and accordingly she was admitted to the California Hospital on July 22, 1913, and placed under my care. At this time she had a slight paresis of the



external rectus muscle of the right side. Temperature 99°, pulse 120, respiration 24; urine acid, 1030; some albumin. She cannot see fingers at a distance of one foot. No tendency to coma. No aphasia.

I operated immediately and was assisted by Dr. Alfred Fellowes, whilst Dr. Connerty maintained a light ether anesthesia. Seeing that the focal signs were too indefinite to justify me in imperiling her speech centres by exploring her left side, I decided upon a right temporal decompression without bone replacement. A large flap with the convexity above, was turned down, exposing the temporal muscle, through the center of which a vertical incision was made to the bone and the two halves retracted together with the subjacent periosteum. The upper two-thirds of the squamous temporal and surrounding three-quarters of an inch of the parietal bone was removed with the De Vilbiss forceps after a small preliminary trephine opening had been made. Hemorrhage from the

bone was arrested with Horsley's wax. The dura was tense and greatly bulging. After ligature of the meningeal vessels with fine catgut, a dural flap with a convexity below was turned up, the lower border of the dural flap being one-quarter of an inch above the bone margin. The brain vessels were intensely engorged. No local resistance or discoloration noticed. It was not deemed advisable after ventricular puncture to remove more than a small amount of fluid at this time, which, however, was not sufficient to allow the dural flap to be stitched in place. Accordingly the dura was simply laid back over the brain and the temporal flap replaced and stitched with silkworm gut and horse hair. The bone was left out altogether and a cigarette drain inserted at the postero-inferior angle. Aseptic gauze dressing applied. The patient was returned to bed in good condition, and was conscious ten minutes later.

July 23, 1913—Headache improved, but a sense of fulness over the site of operation. During the dressing, drain was removed, followed by a discharge of bloody serum, and then by clear cerebrospinal fluid (collected for examination). Immediate relief. Maximum temperature 98.6°, pulse 140, respiration 18. Minimum temperature 97.8°, pulse 112, respiration 14. Comfortable night.

July 24, 1913—Some vomiting following liquid nourishment, and some generalized aphasia—(object blindness, motor difficulty of speech, and deficient appreciation of spoken words). Eyesight improving. The aphasia was evidently due to edema of the left cortex, and accordingly the patient was immediately put up on a back rest, and the same evening the aphasia had cleared up almost entirely and the patient was brighter and better. Discharge less. Absolutely no paresis or sensory defect. Paresthesia of the right little and ring fingers still present. Some edema of the right eyelid causes ptosis. Rectal feeds given. Max. 99.4°, 124, 20; min. 98°, 112, 14. Urine now free from albumin, but acetone present. Pot. iod. continued. Before leaving hospital hernia had increased somewhat.

Subsequent recovery complete and uneventful. Radiogram of the skull shows nothing definite, but in addition to the area of decompression a suspicious thinning of the bone was observed above the internal occipital protuberance. As the eyes recovered, objects appeared to be covered with lace, but this sensation disappeared when recovery was complete.

January 14, 1914—Patient has completely recovered her eyesight and gained 25 pounds in weight; has had no sign of a headache or "cramping spell" since the operation; the same two fingers are still numb, but no anesthesia can be determined. She has been very cheerful and has taken long walks up to the present time. Her intelligence has been as good as it ever was, but the last three days the hernia has increased in size and become tense and very definite aphasia and amnesia noticed. She calls objects by the wrong name, knows what she wants to say, but cannot find the right word. When asked to read a simple sentence she does so, but after six times can not remember what she has read. Realizes her condition and is greatly discouraged. Attributes it to excessive walking. Up to this time hernia had remained the same size, and at the same tension as when she left hospital. Free purgation and rest prescribed and pot. iod. recommenced. The aphasia cleared up in a few days and the hernia again became slack as usual. Discs show no secondary pallor and are but slightly blurred on the nasal side. Lumbar puncture was not performed, as the patient was averse to any sort of operative procedure.

At the present time, July 20, 1914, her health and general condition is better than ever before in her life. She has increased her weight another five pounds and has had no recurrence of any symptoms, and the hernia is diminishing; hence the diagnosis of tumor of the left cortex is almost untenable on the strength of numbness of the two fingers of the right hand. The aphasia is not a focal sign, as it is too generalized, and was not complained of before operation. It might be explained by the possibility of her being one of those rare individuals who, although right-handed, carry their speech centers in the right cortex. It appears to me more probable that some chronic meningitic process may have partially occluded the foramen of Majendie or of Key and Retzius, so that under congestive conditions they almost lose their function and a state of hydrocephalus temporarily results until the exacerbation passes off. This is slightly supported by a positive Von Pirquét reaction, and strongly supported by the old history of symptoms resembling posterior basic meningitis followed by steadily increasing symptoms of intracranial pressure extending over a period of years. Now that she is well, it is my intention to administer injections of tuberculin. Should she again get urgent symptoms, I would consider myself justified in performing simultaneous ventricular and lumbar puncture, to further substantiate diagnosis, followed, if need be, by perforation of the corpus callosum. Whether free communication between the fourth ventricle and the subarachnoid cistern will ever be re-established, time alone will show, but at present it is quite satisfactory so long as she lays no undue strain upon the cerebral circulation. She notices a decided sense of fulness when bending down to lace her shoes. As things are, I think it is a good case to leave alone.

WET NURSE DIRECTORY

Established at the University Hospital.

The importance of human milk for very sick babies or for very young and delicate babies deprived for one reason or another of their own mother's breast milk and the absolute necessity for breast milk for premature infants has led me to establish a directory for wet nurses at the University Hospital. During the last few months we have been having one or more wet nurses constantly attached to the pediatrics service of the University Hospital. During this time we have placed several of our wet nurses, at the request of physicians, in private families or have furnished drawn breast milk to homes where for one reason or another, that was considered the best way to meet the situation.

We are always willing to try to furnish a wet nurse to any physician or to furnish a moderate amount of drawn breast milk if called for at the University Hospital.

To obtain a wet nurse the family must pay a registration fee of $20.00 to the hospital, which is the nominal fee we have found it necessary to charge in order to help meet the expenses of keeping up the directory. The salary for the wet nurse will be from $40.00 to $50.00 per month or $10.00 a week.

Each wet nurse and baby is examined by us and no wet nurse with any signs of tuberculosis, syphilis or gonorrhea will be sent out. Wassermann examinations are done in all cases and a careful history of the wet nurse is taken (most of the wet nurses will be mothers from the University Hospital Maternity Service, where, of course, complete histories and examinations are kept). Each wet nurse is kept under observation long enough to know the character of the woman and the condition of her baby. Her baby's weight is kept and unless it has done well she is not considered a suitable wet nurse. The mother is in most cases